UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

STEPHEN McCOLLUM, and SANDRA McCOLLUM, individually, and STEPHANIE KINGREY, individually and as independent administrator of the Estate of LARRY GENE McCOLLUM, PLAINTIFFS	§	
v.	§	CIVIL ACTION NO. 4:14-cv-3253 JURY DEMAND
BRAD LIVINGSTON, JEFF PRINGLE, RICHARD CLARK, KAREN TATE, SANDREA SANDERS, ROBERT EASON, the UNIVERSITY OF TEXAS MEDICAL BRANCH and the TEXAS DEPARTMENT OF CRIMINAL JUSTICE. DEFENDANTS	§	

Plaintiffs' Consolidated Summary Judgment Response Appendix

EXHIBIT 30

Patient Account: 20005972-517
Med. Rec. No.: (0150)519447P
Patient Name: **BOGGUS, JAMES**
Age: 60 YRS *DOB:* [redacted] *Sex:* M *Race:* C
Admitting Dr.: OUTSIDE TDCJ
Attending Dr.: OUTSIDE TDCJ
Date / Time Admitted : 09/02/11 0753
Copies to :

UTMB
University of Texas Medical Branch
Galveston, Texas 77555-0543
(409) 772-1238
Fax (409) 772-5883

Pathology Report

159 3395

FINAL AUTOPSY REPORT

Autopsy Office (409)772-2858

Autopsy No.: AU-11-00184

AUTOPSY INFORMATION:

Occupation: INMATE Birthplace: UNKNOWN Residence: TEXAS
Date/Time of Death: 9/1/2011 03:59 Date/Time of Autopsy: 9/2/2011
Pathologist/Resident: ARONSON/MANGLIK Service: TDC CONTRACT
Restriction: NONE

***
The on-line version of the final autopsy report is abbreviated. If you would like a copy of the complete final report, or if you have any questions regarding this report, please contact the Autopsy Division Office, (409)772-2858.
***

FINAL AUTOPSY DIAGNOSIS

I.	**Heart: Arrhythmogenic right ventricular cardiomyopathy**	**A1,A2**
	A. Lungs: Congestion and edema	A4
	B. Brain: Cerebral edema, mild	A4
	C. Head and neck: Congestion, marked	A4
	D. Ribs: Multiple fractures (status post CPR)	A4
II.	**Cardiovascular system: Atherosclerosis**	**A5**
	A. Heart: Cardiomegaly due to left ventricular hypertrophy	A5
	B. Kidneys: Benign nephrosclerosis	A5
	C. Brain, basal ganglia: Small vessel disease (arteriolosclerosis)	A5
	D. Aorta: Atherosclerosis, mild	A5
	E. Coronary arteries: Mild calcific atherosclerosis	A5
	F. Cerebral arteries: Mild focal atherosclerosis	A4
III.	**Other findings:**	
	A. Liver: Cirrhosis (hepatitis C)	A5
	B. Prostate: Chronic prostatitis	A5
	C. Ileum: Meckel diverticulum	A5
	D. Cerebral ventricles: Moderate dilation	

CAUSE OF DEATH: Arrhythmogenic right ventricular dysplasia
MANNER OF DEATH: Natural

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****TYPE: Anatomic(A) or Clinical(C) Diagnosis.*
*IMPORTANCE: 1-immediate cause of death (COD); 2-underlying COD; 3-contributory COD; 4-concomitant, significant; 5-incidental ****

Patient Name: BOGGUS, JAMES
Patient Location: AUTOPSY
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Continued....

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CLINICAL SUMMARY:

The following summary is based on information obtained from medical records and provided by Investigator Slater, OIG. Photographs of the scene and of re-enactments of the the position of the decedent were also reviewed.

The decedent is a 60 year old Caucasian male with history of hepatitis C, gastroesophageal reflux disease (GERD), hypothyroidism, hypertension, and bipolar disorder. His medications were fluoxetine, Nortriptyline, Ranitidine and Diphenhydramine. He had past social history of alcoholism, drug abuse and smoking.

Approximately one week prior to his death, he was admitted to Palestine Regional Hospital on 8/24 for treatment of heat exhaustion.

On 8/31/2011, the day prior to death, he had an episode of dizziness and weakness during medical examination. Vital signs at that time included BP 156/90, rectal temperature 101F. He was given water and his usual medications. Later that evening, between 12:30 and 1:00 am, the offender complained of being hot and he took a shower. After the shower, he was noted to be talking incoherently and acting strangely. Body temperature was not recorded at this time. Per telephone triage at 03:00, the nurse practitioner instructed the officer to bring the patient to Beto unit for further evaluation. The patient was placed in a van, handcuffed, seated on a bench, with an upright mattress separating him from the wire cage wall in the back of the van. After a short ride to the gate of Beto unit, he was seen at 03:50 to be lying on his back on the bench with his feet toward the door, breathing, but not responding to questions. The gate was closed, the van proceeded 400 yards, and the back of the van was opened. At this time (03:51), the officers that first opened the door noted that the offender was unresponsive, not breathing, on his back on the bench with his left shoulder against the mattress. As the officer entered the back of the van to extract the patient, the body slid downward toward the floor and became wedged between the bench and the mattress. When the nurse arrived he was wedged between the bench and the mattress, and it took about 7 minutes to remove him from the van. CPR was started at 03:58 and no shock was advised as per AED. EMS arrived at 04:37. CPR was stopped and he was pronounced dead at 04:41 on 9/1/2011. A complete autopsy was performed on 9/2/2011.

NM /da
09/12/11

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Continued....

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GROSS DESCRIPTION:

EXTERNAL EXAMINATION: The decedent, identified by wrist bracelets as "Boggus James", is an obese, well-developed, Caucasian/ white male, measuring 178 cm in length. The general appearance is consistent with the reported age of 60 years. The body is clad in drawers only. There is no personal belonging accompanying the body. Rigor mortis is present in the legs, arms. The head, face, neck, and upper chest show pronounced purple congestion. Skin turgor appears normal.

The head is normocephalic with short black hair. The irides are brown with equal pupils measuring 0.3 cm in diameter. The corneas are transparent, the conjunctivae and the sclerae are normal. Bilateral arcus senilis is present. The nares are patent. Dentition is poor and buccal membranes are unremarkable. The trachea is midline. Palpation of the neck reveals no lymphadenopathy or thyromegaly.

Body hair distribution is normal male. The chest diameters are normally proportioned. The abdomen is protuberant. Lymph nodes in the supraclavicular, axillary and inguinal regions are not palpable. The genitalia are normal uncircumcised male for the age. The back is normal. The finger and toe nails are unremarkable. There are abrasions around bilateral elbows, right shin and medial side of left great toe.

The following evidence of medical intervention is present: An oropharyngeal airway, EKG pads and defibrillator pads are identified in proper locations.

The following marks and scars are present: A 8 cm well healed scar on right lower abdomen is identified.

INTERNAL EXAMINATION: The body is opened using a standard Y incision, to reveal a 3.4 cm thick panniculus and the thoracic and abdominal organs in the normal anatomic positions. The left and right pleural cavities contain approximately 7-10 cc of fluid. The pericardial sac contains 5 cc of fluid. No thromboemboli are found in the large pulmonary arteries.

The abdominal cavity contains 50 cc of fluid. Umbilical hernia with omentum in hernia sac is noted. There are no peritoneal adhesions.

There are fractures of ribs 6, 7, 8 on the right and 5, 6, 7 ribs on the left, anteriorly.

CARDIOVASCULAR SYSTEM: Heart: The heart weighs 590 gm (normal male 270-360). The pericardium is smooth and glistening. The coronary arteries show some calcifications. The heart is examined by cross sections through the ventricles and opened following the flow of blood. The endocardium is normal. The left ventricular wall is 1.6 cm thick (normal 1.0-1.8 cm) at the junction of the

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GROSS DESCRIPTION:

posterior papillary muscle and free wall. The right ventricle wall is 0.4 cm thick (normal 0.25-0.3 cm) 2 cm below the pulmonic valve annulus. There is extensive infiltration of the right ventricular free wall by adipose tissue, with nearly full thickness replacement by fat in areas, especially near the apex, where the myocardium measures less than 0.1 cm in thickness.

The valves are all grossly unremarkable. Valve circumferences measured on the fresh heart are: tricuspid valve 13.5 cm (normal 12-13 cm), pulmonic valve 10 cm (normal 8.5-9.0 cm), mitral valve 11.5 cm (normal 10.5-11.0 cm), and aortic valve 8.0 cm (normal 7.7-8.0 cm). The foramen ovale is closed.

Blood vessels: The coronary circulation is left dominant (based on the origin of the posterior descending artery). The coronary arteries reveals mild to moderate 3 vessels atherosclerosis with with up to 30-40% stenosis in right coronary artery (RCA) 1cm from origin, 50-60% stenosis in left anterior descending (LAD) 2.5 cm from the origin and up to 30% stenosis in left circumflex 0.5 cm from origin. There is no evidence of hemorrhage or rupture of the plaques.

The aorta exhibits mild atherosclerosis. The celiac, superior and inferior mesenteric, renal arteries are normal. The superior and inferior vena cavae and their branches are normal. The portal vein is normal.

RESPIRATORY SYSTEM: Larynx and trachea: The tracheal mucosa shows a demarcated area of congestion. The laryngeal mucosa and the vocal cords are normal.

Lungs: The right lung weighs 690 gm (normal male 435), and the left 600 gm (normal male 385). The pleural surfaces are normal. The left lung is distended with formalin before sectioning and right lung is examined unfixed. The bronchial and vascular trees are normal. The lung parenchyma is normal with slight congestion. The hilar nodes are normal.

GASTROINTESTINAL TRACT: Esophagus: The mucosa is unremarkable. The esophagus is firmly anchored to the diaphragm.

Tongue: The tongue has a finely granular surface and show small areas of hemorrhage anteriorly.

Stomach and duodenum: The stomach mucosa is unremarkable with normal rugosity. Stomach and duodenum contain 500 ml of chyme.

The duodenal mucosa is unremarkable.

Pancreas: The pancreas has a normal conformation. It is gray-pink, normally

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GROSS DESCRIPTION:

lobulated and firm. The pancreatic duct is patent.

Biliary tract: The gallbladder serosa is gray-green and glistening. The gallbladder contains 30 ml of green bile. The mucosa is green. The wall measures up to 0.1 mm thick, and is unremarkable. The cystic duct, hepatic duct, and common duct are normal, and bile is expressed freely from the ampulla on compressing the gallbladder.

Liver: The liver weighs 1300 gm (normal male 1400-1900). The liver surface is nodular. Glisson's capsule is opaque and glistening. The liver is serially sliced to reveal diffuse macro- and micro - nodularity. No masses are seen. Small Bowel: The serosa is smooth, transparent with no adhesions. The bowel is normal throughout. The lumen contains fecal material. The wall is 0.1 cm thick. The mucosa is normal. There is a Meckel's diverticulum located 165 cm proximal to the ileocecal valve. The mucosa within the diverticulum is normal, with no solid areas or nodules present.

Large bowel: The serosa is transparent. The wall is 0.2 cm thick.

Rectum and anus: The rectum and anus are normal.

Reticulo-Endothelial System: Spleen: The spleen weighs 190 gm (normal 125-195 gm). The cut surface showed unremarkable parenchyma.

Lymph nodes: Lymph nodes in the mediastinum, abdomen and retroperitoneum are unremarkable.

Spine: The spine is normal.

Bone marrow: The thoracic and lumbar spine marrow is grossly normal. The trabeculae and cortical bone are normal density.

GENITO-URINARY SYSTEM: Kidneys: The right kidney weighs 170 gm and the left 190 gm (normal male 125-170 gm). The capsules strip with ease to reveal shallow ill-defined cortical scarring. Serial slicing reveals poorly demarcated cortico-medullary junctions. The cortices are 0.3-0.8 cm thick; the medullas 1.2-1.8 cm thick. The pelves and calyces are normal. Renal pelvic mucosa is normal.

Ureters: The ureters are normal throughout their length, measuring 0.2 mm in maximal external diameter. They are probe-patent into the bladder.

Bladder: The bladder is mildly trabeculated. The trigone is normal.

Prostate: The prostate is normal in size with some calculi in the parenchyma

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GROSS DESCRIPTION:

ranging in size from 0.1 to 0.2 cm. The seminal vesicles are normal.

Testes: The right testis weighs 23 gm, and the left 29 gm (normal 20-25 gm). The tunica albugineas are tan-white, smooth and glistening. The cut surfaces are soft and tan-yellow, with tubules which string with ease.

ENDOCRINE SYSTEM: Thyroid: The thyroid weighs 27 gm (normal 10-22 gm), and is red-brown, bosselated and glistening. The cut surface is homogenous red brown.

Adrenals: The right adrenal weighs 7.0 gm and the left 11 gm (normal 5-6 gm). The adrenals have a normal conformation and position. Serial slicing in the transverse plane reveals autolyzed golden cortices, with gray soft medullae. Serial slicing in the transverse plane reveals no lesion.

BRAIN AND SPINAL CORD: The scalp, calvarium, base of the skull and dura mater are normal. The brain weighs 1450 gm (normal male 1200-1400). The gyri and sulci display a normal pattern without edema or atrophy. The circle of Willis, basilar and vertebral arteries show mild atherosclerosis. No indentation/herniation of the cingulate gyri, unci or molding of the cerebellar tonsils is noted. The brain is fixed in formalin for later examination by a neuropathologist (see neuropathology report).

SPINAL CORD: The grossly normal spinal cord is fixed in formalin for later examination by a neuropathologist.

PITUITARY GLAND: The grossly normal pituitary gland is fixed in formalin for subsequent examination by a neuropathologist.

Samples of liver, kidney, heart, lung, spleen were frozen for potential further examination.

NM /da
09/12/11

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MICROSCOPIC DESCRIPTION:

HEART, Ventricles left and right, Slides 15- 17(left), 18 (septum), 19, 20, 21(Right), (7 H & E, 2 Masson trichrome): The sections from heart show replacement of myocardial cells with fibrofatty tissue starting from subepicardium and extending to the endocardium in few areas in right ventricle.The left ventricle and interventricular septum showed similar fibrofatty replacement without full wall thickness. No inflammatory infiltrate is seen. The finding are consistent with arrythmogenic right ventricular dysplasia / cardiomyopathy.

HEART, Conduction system, SA (slides 28-33) and AV (slides 34-37) node, (10 H&E): The SA and AV node fibers show normal histology without significant infiltration by fat, inflammation or acute changes.

CORONARY ARTERY, left anterior descending, Slide 2, (1 H&E): Sections show up to 60% stenosis by an eccentric atheromatous plaque. No acute plaque changes, such as rupture of or hemorrhage into the plaque, are seen.

CORONARY ARTERY, left circumflex, Slide 3, (1 H&E): Sections show up to 30% stenosis by a concentric atheromatous plaque. No acute plaque changes, such as rupture of or hemorrhage into the plaque, are seen.

CORONARY ARTERY, right, Slide 1, (1 H&E): Sections show 50% stenosis by an eccentric atheromatous plaque. No acute plaque changes, such as rupture of or hemorrhage into the plaque, are seen.

LIVER, slide 4 (1 H&E): The tissue is poorly preserved. Advanced autolytic changes include gas bubbles due to post-mortem bacterial action. There is micro and macro nodular cirrhosis with moderately dense lympho-plasmacytic infiltrate in fibrous septa and extensive macrovesicular steatosis.,
SPLEEN, Slide 5, (1H&E): There is extensive autolysis but no discernible pathologic change.

KIDNEY, left (slides 8-9) and right (slides 6-7) (4 H&E): Sections show areas with globally sclerosed glomeruli, tubular atrophy, thyroidization of tubules, moderate chronic interstitial inflammation corresponding to overlying cortical scars. Intimal thickening of arteries is prominent and hyaline arteriolosclerosis is noted.

ADRENAL GLANDS, Slides 10, (1H&E): No pathologic change is identified.

PANCREAS, Slide 11, (1 H&E): Extensive autolysis precludes microscopic evaluation.

THYROID, Slide 12, (1 H&E): No pathologic change is identified.

Continued....

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TESTIS, right, Slide 13, (1 H&E): No pathologic change is identified. Active spermatogenesis is present.

PROSTATE, Slide 14, (1 H&E): Patchy periglandular chronic inflammatory cell infiltration is seen.

LUNGS, left and right, respectively, Slides 22, 23 and 24, (3 H&E): Sections show alveolar hemorrhage and edema.

STOMACH AND ESOPHAGUS, Slide 25, (1 H&E): No pathologic change.

JEJUNUM AND COLON, Slide 26, (1 H&E): Extensive autolysis with no pathologic change.

VERTEBRA, Slide 27, (1 H&E): Trilineage hematopoiesis is present. The overall cellularity is 40-50% with a normal myeloid to erythroid ratio (3:1) and normal maturation in all three lineage.

SKELETAL MUSCLE, slide 38 (1 H&E): There is no evidence of myofiber degeneration or necrosis.

POST-MORTEM LABORATORY TESTS:

TOXICOLOGY, performed on post-mortem heart blood by Aegis Sciences Corp.
Alcohol, volatiles: Negative
Acetaminophen: None detected
Amphetamines: None detected
CNS stimulants: None detected
Barbiturates: None detected
Carispoprodol/meprobamate: None detected
Methodone: None detected
Benzodiazepines: None detected
Cannabinoids: None detected
Cocaine metabolites: None detected
Opiates: None detected
Meperidine: None detected
Fentanyl analogues: None detected
Pentazocine: None detected
Phenothiazines: None detected
Salicylates: None detected
Tricyclic antidepressants: Positive
Nortryptiline: Positive, 791 ng/mL
Atypical antidepressants: Positive
Fluoxetine: Positive, 810 ng/mL

Continued....

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Desmethylfluoxetine: Positive, 740 ng/mL
Antipsychotics: None detected
Diphenhydramine: Cancelled due to insufficient sample quantity

VITREOUS ELECTROLYTES (performed at UTMB Laboratories):
291 mOsm/kg
Na, K, Cl, Urea nitrogen: Cancelled due to inadequate sample quality

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11/07/11

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Pathology Report

NEUROPATHOLOGY CONSULTATION

Neuropath Office (409)772-2881

Autopsy No.: AU-11-00184

CLINICAL HISTORY:

The decedent is a 60 year old man with past medical history of hepatitis C, hypothyroidism, and hypertension. In the days prior to his death, he suffered episodes of hyperthermia and was briefly admitted to Palestine Regional Hospital on 8/24 for treatment of heat exhaustion. On 9/1/2011 at 03:00, he was noted by guards to be "acting strange" and somewhat sluggish. There were no notations about his temperature. He was transferred to a van for transport, and en route he suffered an arrest at 03:58. CPR was initiated and no shock was advised per AED. He could not be resuscitated and was pronounced dead after approximately an hour of CPR. A complete autopsy was performed on 9/2/2011.

Autopsy revealed an enlarged heart with fatty infiltration of the right and left ventricular myocardium and a very thin right ventricle. The coronary arteries showed only mild to moderate atherosclerosis. There was no acute myocardial infarct noted. Determination of the cause and manner of death are pending additional studies, including toxicology, biochemistry, (to evaluate for possible heat related death), histologic examination, and additional scene information.

Pathologist/Resident: Aronson/Manglik

GROSS DESCRIPTION:

Submitted for neuropathologic examination are brain (unfixed weight 1450 g), convexity and posterior fossa dura, spinal cord with spinal dura (length 33 cm, conus medullaris and filum terminale present), and pituitary gland.

The dura is grossly unremarkable. There is no evidence of significant jaundice staining. There is no evidence of acute hemorrhages, subdural membranes, or masses. There is no evidence of thrombosis of the superior sagittal sinus.

External examination reveals the brain to be intact and normally developed with transparent convexity leptomeninges. There is no evidence of arachnoid hemorrhage, exudate, focal softening, discoloration, atrophy, swelling or herniation. The major cerebral arteries have mild focal atherosclerosis. The circle of Willis has a normal symmetric pattern, and no aneurysms or other malformations are identified.

The hemispheres are sliced coronally, revealing normal anatomic development and moderately dilated cerebral ventricles. The cortical ribbon is normal in thickness and appearance, the cerebral white matter is normally myelinated, but central structures are pink and poorly fixed. The gray-white junction is distinct throughout. No focal lesions are identified in the hemispheres.

The brainstem and cerebellum are separated through the cerebellar peduncles, and the cerebellum is sliced sagittally and the brainstem transversely. Both

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NEUROPATHOLOGY CONSULTATION

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GROSS DESCRIPTION:

structures are normally developed, and have normal pigmentation of substantia nigra and locus ceruleus. There is no evidence of gross lesions.

The spinal dura is opened anteriorly, revealing no evidence of extradural, subdural or arachnoid hemorrhage. The spinal cord is sliced transversely at 0.5 to 1 cm intervals, revealing normal development and no evidence of parenchymal lesions.

The pituitary gland is intact and normally developed, without external hemorrhages or other lesions. The horizontal cut surface reveals normal anterior and posterior lobes, and no evidence of internal lesions.

Photographs made during gross brain examination: none.

DICTATED BY: GERALD A. CAMPBELL, M.D., PATHOLOGIST
09/16/11

SECTIONS TAKEN:

B1: Pituitary gland; B2: Right frontal, area 8; B3: Right basal ganglia; B4: Right hippocampus; B5: Right cerebellum.

FINAL DIAGNOSES:

A. Brain and cranial dura (weight 1450 g):
1. Cerebral arteries, major: Mild focal atherosclerosis
2. Basal ganglia: Small vessel disease (arteriolosclerosis), moderate
2. Cerebral ventricles: Moderate dilation
3. Deep white and gray structures: Poor fixation, suggestive of mild edema

B. Spinal cord and spinal dura (33 cm caudal segment): No abnormalities

C. Pituitary gland: No abnormalities

COMMENTS:

Small vessel disease in this context refers to medial thickening and/or hyalinization of small parenchymal arteries and arterioles, and in some cases increased adventitial collagen of small veins and venules.

***
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UTMB
University of Texas Medical Branch
Galveston, Texas 77555-0543
(409) 772-1238
Fax (409) 772-5683

Pathology Report

NEUROPATHOLOGY CONSULTATION

Neuropath Office (409)772-2881

Autopsy No.: AU-11-00184

COMMENTS:
***

GERALD A. CAMPBELL, M.D., PATHOLOGIST
Division of Neuropathology .

Patient Name: BOGGUS, JAMES
Patient Location: AUTOPSY
Room/Bed:
Printed Date / Time: 12/21/11 - 1542

Patient Account: 20005972-517
Med. Rec. No.: (0150)519447P
Patient Name: **BOGGUS, JAMES**
Age: 60 YRS *DOB:* [redacted] *Sex:* M *Race:* C
Admitting Dr.: OUTSIDE TDCJ
Attending Dr.: OUTSIDE TDCJ
Date / Time Admitted: 09/02/11 0753
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Galveston, Texas 77555-0543
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Pathology Report

(Electronic Signature).

Gross: 09/16/11
Final: 09/23/11

Patient Name: BOGGUS, JAMES
Patient Location:
Room/Bed:
Printed Date / Time: 12/21/11 - 1542

AUTOPSY *Page:*

Patient Account: 20005972-517
Med. Rec. No.: (0150)519447P
Patient Name: **BOGGUS, JAMES**
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Admitting Dr.: OUTSIDE TDCJ
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Copies to :

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Galveston, Texas 77555-0543
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Fax (409) 772-5683
Pathology Report

FINAL AUTOPSY REPORT

Autopsy Office (409)772-2858

Autopsy No.: AU-11-00184

CLINICOPATHOLOGIC CORRELATION:

This 60 year old offender with a history of bipolar disease, chronic hepatitis C and hypertension, died suddenly while en route to a medical unit for treatment of altered mental status. A few days prior to death, he had been hospitalized for heat exhaustion.

Autopsy revealed a major unexpected finding in the heart; there was extensive infiltration of the right ventricular myocardium by adipose tissue, with focal full thickness replacement of the ventricular free wall by fat. The pattern and distribution of fat infiltration is characteristic of arrythmogenic right ventricular cardiomyopathy. This pathologic picture is thought to represent a progressive degeneration of myofibers with replacement by fat and scar. The cause of ARVC is not known, but genetic studies suggest that abnormalities of proteins associated with desmosomes may be responsible in some kindreds. The most typical clinical manifestation is arrhythmia; ARVC is a known cause of sudden death in athletes. In the present case, we believe ARVC to be the underlying cause of death.

Post-mortem toxicology was negative for drugs of abuse. Levels of tricyclic antidepressants and atypical antidepressants were not in the lethal range, especially when accounting for post-mortem redistributionof drug. These medications were prescribed to the decedent.

The initial descriptions of the scene suggested the possibility of positional asphyxia, however, further investigative information weighs against this. We also considered the possibility of environmental hyperthermia; however, analysis of osmolality of the vitreous fluid did not suggest dehydration, and in the absence of information regarding body temperature, there is insufficient suport for this diagnosis.

It is our judgment that it is the underlying heart disease (ARVC) that caused his death. The additional factors of heat stress and treatment with antidepressants (drugs that can affect cardiac conduction and heat dissipation) cannot be ruled out.

Incidental findings included cirrhosis due to chronic hepatitis C, and vascular changes in various organs attributed to hypertension.

In summary, it is our opinion that the cause of death is arrhythmia due to arrhythmogenic right ventricular cardiomyopathy. The manner of death is natural. Family members should be aware that this condition can be hereditary.

Continued....

Patient Account: 20005972-517
Med. Rec. No.: (0150)519447P
Patient Name: BOGGUS, JAMES
Age: 60 YRS *DOB:* [redacted] *Sex:* M *Race:* C
Admitting Dr.: OUTSIDE TDCJ
Attending Dr.: OUTSIDE TDCJ
Date/Time Admitted: 09/02/11 0753
Copies to:

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Fax (409) 772-5683
Pathology Report

FINAL AUTOPSY REPORT

Autopsy Office (409)772-2858

Autopsy No.: AU-11-00184

CLINICOPATHOLOGIC CORRELATION:

Reference:

Thiene G, Corrado D, and C Basso. Arrhythmogenic right ventricular cardiomyopathy/dysplasia. Orphanet Journal of Rare Diseases, 2007 2:45

JA /JA
12/21/11

JUDITH F. ARONSON, M.D., PATHOLOGIST (Electronic Signature)

12/21/11

Patient Name: BOGGUS, JAMES
Patient Location: AUTOPSY
Room/Bed: -
Printed Date/Time: 12/21/11 - 1542

END OF REPORT

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

STEPHEN McCOLLUM, and SANDRA McCOLLUM, individually, and STEPHANIE KINGREY, individually and as independent administrator of the Estate of LARRY GENE McCOLLUM, PLAINTIFFS	§	
v.	§	CIVIL ACTION NO. 4:14-cv-3253 JURY DEMAND
BRAD LIVINGSTON, JEFF PRINGLE, RICHARD CLARK, KAREN TATE, SANDREA SANDERS, ROBERT EASON, the UNIVERSITY OF TEXAS MEDICAL BRANCH and the TEXAS DEPARTMENT OF CRIMINAL JUSTICE. DEFENDANTS	§	

Plaintiffs' Consolidated Summary Judgment Response Appendix

EXHIBIT 31

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

DAVID BAILEY, ET AL	*	**4:14-CV-01698**
	*	
VS.	*	**9:05 A.M.**
	*	
BRAD LIVINGSTON, ET AL	*	**JUNE 2, 2016**

HEARING ON PRELIMINARY INJUNCTION AND CLASS CERTIFICATION
BEFORE THE HONORABLE KEITH P. ELLISON
Volume 4 of 4 Volumes

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Court Reporter:
Laura Wells, RPR, RMR, CRR
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Houston, Texas 77002

Proceedings recorded by mechanical stenography.
Transcript produced by computer-assisted transcription.

VOLUME 4
(Hearing on Preliminary Injunction and Class Certification)

June 2, 2016

PROCEEDINGS

THE COURT: Sit down everyone.

Okay. It's defendants' turn to call a witness.

MR. BOYD: Defendants call Dr. Dean Rieger to the stand.

THE COURT: All right. Yes, sir. Can you make your way up here. You probably know the drill by now. We are going to have you in the seat near me.

(Witness sworn by the case manager.)

THE WITNESS: Yes.

THE COURT: Please adjust the mic and speak directly into it.

All right. You may inquire.

MR. BOYD: Thank you, Your Honor.

DEAN PAUL RIEGER, M.D., MPH

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. BOYD:

Q. Doctor, could you please introduce yourself to the Court?

A. I'm Dean Rieger, MD, MPH.

Q. Where are you currently employed, Dr. Rieger?

A. I retired approximately three weeks ago.

Q. From where did you retire?

A. I retired from Correct Care Solutions.

was a significant risk in TDCJ prior to 2011-2012.

The question of the deaths that occurred during the summer of 2011 is a different issue. So I didn't want to -- I didn't want to link one to the next with such a
11:33:02 sequential -- with those two questions being so sequential.

Q. (By Mr. Edwards) Then I'll just ask: You would tell me that clearly, in your opinion, TDCJ would have recognized a serious risk from the heat inside its prisons
11:33:16 at the time in which they enacted practices or policies to deal with that risk? Is that a fair statement?

A. Yes.

Q. Okay. And so, I have heard a lot throughout this case about, you know, an e-mail going out with precautions.
11:33:29 And you have seen that, right?

A. Yes.

Q. And you consider that to be a practice that TDCJ has had in place to deal with the risks from extreme heat, right?

11:33:40 **A.** I would consider that to be part of a process. It's not -- it's not a freestanding thing. That's a reminder e-mail that goes out.

Q. I'll represent to you that Cynthia Burton, lead counsel for the defendants, stated unequivocally in a
11:33:57 preliminary injunction hearing that that e-mail precaution

going out was the exact same thing for TDCJ as a policy.

MR. EDWARDS: Did I misspeak, Ms. Burton?

Q. (By Mr. Edwards) If that's the case, would you agree that -- that when those e-mail messages started going out TDCJ would have been aware of the significant risk in its facilities from heat inside?

MR. BOYD: Your Honor, I'm just going to object to the extent that this calls -- that he is trying to elicit any sort of a legal conclusion about the distinction between practice and policy in the law and trying to get Dr. Rieger to make -- to tie him to any --

MR. EDWARDS: No, I am not.

THE COURT: His question is on the concept of risk, which I think his attorney can speak to. I understand. Obviously, I understand he is not a lawyer. I do understand that.

A. I think TDCJ was aware of the risk before they ever sent an e-mail out. The e-mail -- I haven't done a side-by-side comparison between the e-mail and the policy or between the e-mail and the UTMB policy. I haven't done any side-by-sides.

Accepting your representation that those e-mails word-for-word match one or the other, the policy still would have had to pre -- the existence of the policies still would have preceded the e-mails.

So I don't think it's a fair statement to say that the e-mail is the policy. The e-mail may quote the policy; but the policy exists in advance of a reminder e-mail that goes out to say, "Wardens, it's that time of year again. Make sure your staff is doing this. You are expected to do this."

11:35:31

And UTMB -- or if it goes to the UTMB people, I'm not sure. I don't know all the recipients of the e-mails. If that e-mail goes to UTMB and says, "Hey, remind your staff this is going on and these are the things that you kind of expect and recognize as heat-stress injuries," do I think that's part of a heat-stress injury risk mitigation effort? The answer is yes.

11:35:48

Q. (By Mr. Edwards) Okay. You touched on something. You don't consider -- I guess if -- outside of the representations that Ms. Burton may have made or that have been made to this Court, you would consider the e-mail just part of an overall -- you wouldn't consider that e-mail in and of itself a policy; is that fair?

11:36:01

A. To me a policy is a document which provides general directions, sometimes philosophical, sometimes informational, sometimes operational as to what a group -- sometimes of facilities, sometimes a group of certain types of employees -- is expected to do in the course of their duties. It's a policy.

11:36:18

11:36:44

Q. Okay. And that's important to have a policy in writing that's applicable to the various facilities so that everybody knows what they have to do and there isn't discretion down below so that human error is minimized, right?

A. Well, the hope is that everyone will read, incorporate, understand and apply the policy. Policies typically have associated procedures or practices sometimes called in correctional environments post orders. There are a host of types of processes for implementing policy. One would hope that whatever TDCJ uses to implement policy was used in the course of implementing the heat stress injury mitigation policy.

Q. Do you know when the respite area idea was formalized even into an e-mail?

A. No.

Q. You mentioned that I believe -- I want to make sure I'm characterizing it correctly. You said that the inmates had testified and provided documents to you that they had free access to these respite areas, right?

A. No. The inmates had given some sort of declaration that I believe you guys filed.

Q. Right.

A. Not -- they didn't testify to me.

Q. And I'm less concerned with the form of it than the

making the changes. But I don't think one person would do that. I think it would be more than one person.

Q. Sure.

A. But in essence, yes.

01:06:09 **Q.** However the system is designed, whoever is in charge, whether they delegate that power or not, somebody needs to look at these, investigate, evaluate, analyze and make changes, if necessary, fair?

A. That's fair.

01:06:21 **Q.** Okay. When we discussed -- I mean, this is a staggering amount of heatstroke deaths, right? These are -- by the way, these are confirmed deaths by hyperthermia of Texas inmates.

A. I mean, I don't like the word "staggering."

01:06:39 **Q.** That's fine.

A. But this is certainly a significant amount of heatstroke deaths during that 2011 heat wave.

Q. I apologize. That is the word you used in your deposition. So I will use "significant." And I point you

01:06:50 to these deaths -- again, and these were -- you told me that the deaths in 1998 stood out in your mind. Do you recall that?

A. I don't recall saying that specifically, but as I look at -- I see three 1998 deaths here. I can't tell if there

01:07:12 is one above it, also.

Q. I believe there are three in 1998, sir.
A. As I look at them again, they stand out because I see a psychosis-producing disorder in the diagnosis list for each of the three.
01:07:33 **Q.** Okay. And what is significant about that is anybody who took the time to look at this with any sort of acumen or policymaking knowledge would look at that list and say, look, we have a potential problem with inmates with psychosis and heat, right?
01:07:53 **A.** I think that's fair.
Q. Okay. And then if I was counting, before the summer of 2011 I count eight heatstroke deaths; is that accurate?
A. That's accurate.
Q. Okay. You would tell the Court that is a very
01:08:11 significant number of deaths that policymakers ought to be looking at in evaluating and trying to make changes, right?
A. Let me say the same thing that I think I said during deposition, which is that every death is significant.
01:08:24 Every death deserves careful examination. So given that I expect a careful mortality review to be performed after each and every death, certainly the deaths are significant. I mean, I can't sit here and say, you know, seven deaths aren't significant when I believe one is.
01:08:43 **Q.** Okay. And I'm not talking about kind of the tag line

every death is tragic. We care about everybody. I assume you believe that, right?

A. I don't mean it because of that. I mean it because the reason that we do mortality reviews is very similar to the reasons that hospitals used to do autopsies on almost everyone. We can learn from deaths. We can learn how to take care of our patients and improve what we do in the future. And that's why every death is important as a clinician.

Q. You are not just talking for moral reasons every death is important?

A. That's right.

Q. You are talking about, look, every death is important because -- and I quote, we -- "Administrators need to respond and make changes to reduce the risk of recurrence," right?

A. That's correct. Whoever said that must have been extremely intelligent.

Q. He was.

A. Could you attribute that to someone?

Q. Right now it's 50/50 which one. So I've got a 50 percent chance that's it's somebody intelligent. I think you did say it.

And then, you also said, "It should be analyzed, the deaths; and gaps in policy and practice need to be

THE COURT: It's not just that. I'm worried about you being prejudiced on appeal.

MR. GREER: I think both sides want the record to be clear.

05:16:55 MR. SINGLEY: We'll get together and straighten it out, Your Honor.

THE COURT: All right. Thank you very much.

(Proceedings concluded at 5:16 p.m.)

Date: June 10, 2016

COURT REPORTER'S CERTIFICATE

I, Laura Wells, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

/s/ Laura Wells

Laura Wells, CRR, RMR

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

STEPHEN McCOLLUM, and SANDRA McCOLLUM, individually, and STEPHANIE KINGREY, individually and as independent administrator of the Estate of LARRY GENE McCOLLUM, PLAINTIFFS	§	
v.	§	CIVIL ACTION NO. 4:14-cv-3253 JURY DEMAND
BRAD LIVINGSTON, JEFF PRINGLE, RICHARD CLARK, KAREN TATE, SANDREA SANDERS, ROBERT EASON, the UNIVERSITY OF TEXAS MEDICAL BRANCH and the TEXAS DEPARTMENT OF CRIMINAL JUSTICE. DEFENDANTS	§	

Plaintiffs' Consolidated Summary Judgment Response Appendix

EXHIBIT 32

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

DAVID BAILEY, ET AL	*	**4:14-CV-01698**
	*	
VS.	*	**9:16 a.m.**
	*	
BRAD LIVINGSTON, ET AL	*	**MAY 26, 2016**

HEARING ON PRELIMINARY INJUNCTION AND CLASS CERTIFICATION
BEFORE THE HONORABLE KEITH P. ELLISON
Volume 1 of 4 Volumes

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Proceedings recorded by mechanical stenography.
Transcript produced by computer-assisted transcription.

VOLUME 1
(Hearing on Preliminary Injunction and Class Certification)

May 26, 2016

MS. BURTON: I'll pass the witness, Your Honor.

THE COURT: Thank you very much. Thank you very much.

Your inquiry, Mr. Edwards.

11:06:46 MR. EDWARDS: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. EDWARDS:

Q. Just give me one moment, please, Mr. Ginsel.

THE COURT: Okay.

11:07:08 **A.** Okay.

MR. EDWARDS: David, you may need to help me figure this out.

Q. (By Mr. Edwards) True or false. Is it correct that there is no formal heat wave policy at TDCJ?

11:07:37 **A.** I would not agree with that characterization.

Q. Well, tell me the document that you contend is a formal heat wave policy for TDCJ.

A. We utilize our incident command system, which is a document in our emergency plan for unusual weather events.

11:08:00 So that would be -- for TDCJ's purposes on how to handle heat-related -- and I'm assuming you are talking about extended periods of heat. Then we're going to use our incident command system to manage that particular situation.

11:08:15 **Q.** Okay. Just so I am clear, you are here to talk on

behalf of the Texas Department of Criminal Justice, correct?

A. I'm here in my official capacity.

Q. As the deputy director of training and policy at the Texas Department of Criminal Justice, correct?

A. Now, plans and operations, which has the policies that relate directly to the correctional institutions division, we're a proponent. Executive services is the maintainer of all policies for the agency.

Q. Does the incident command policy you are referring to, is that a formal directive, like an AD, administrative directive, with a number?

A. It's considered our emergency management plan, Volume 4 of our emergency -- of our policies and procedures.

Q. Does it give any specific directives to wardens what to do if there is a heat wave?

A. Does it give specific? It gives you direction on what to do in the event of weather-related events. And those weather-related events may be a tornado, hurricanes. It can vary in nature.

Q. It makes no distinction between a hurricane, a tornado or a heat wave; is that fair?

A. That would be fair.

Q. Is it fair to say, then, that TDCJ acknowledges that a

this proceeding.

THE COURT: Okay. Take a moment to worry about that, and I'll take it up when we start tomorrow morning.

Anything further before we recess?

03:49:28 (No response.)

THE COURT: Thank you all very much.

(Proceedings adjourned at 3:49 p.m. and continued in Volume 2.)

Date: June 7, 2016

COURT REPORTER'S CERTIFICATE

I, Laura Wells, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

/s/ Laura Wells

Laura Wells, CRR, RMR